

		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0001644</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>PERSHING CONVALESCENT HOME</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>10/01/99</u> to <u>9/30/00</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>3900 S. OAK PAK AVENUE</u> <u>STICKNEY</u> <u>60402</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>COOK</u>		(Signed) _____ (Date) _____	
Telephone Number: <u>708-484-7543</u> Fax # <u>708-484-7586</u>		(Type or Print Name) <u>LESTER EDELSON</u>	
IDPA ID Number: <u>362528894001</u>		(Title) <u>ASSISTANT ADMINISTRATOR</u>	
Date of Initial License for Current Owners: <u>09/02/52</u>		(Signed) _____ (Date) _____	
Type of Ownership:		(Print Name and Title) <u>JEFFREY T. STUART, C.P.A.</u>	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____		(Firm Name & Address) _____ (Telephone) <u>847-945-2888</u> Fax # <u>847-945-9512</u>	
<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____		(Date) _____	
<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
In the event there are further questions about this report, please contact: Name: <u>JEFFREY STUART</u> Telephone Number: <u>847-945-2888</u>			

#	0001644	Report Period Beginning:	10/01/99	Ending:	9/30/00
---	---------	--------------------------	----------	---------	---------

D. How many bed-hold days during this year were paid by Public Aid?

03-16-88

0 (Do not include bed-hold days in Section B.)

1

F. Does the facility maintain a daily midnight census? YES

YES ☐ NO ☒

YES ☒ NO ☐

Date started 01/27/64

YES ☐ Date _____ NO ☒

of beds certified and days of care provided

Medicare Intermediary**MODIFIED**

ACCRUAL	<input checked="" type="checkbox"/>	CASH*	<input type="checkbox"/>	CASH*	<input type="checkbox"/>
---------	-------------------------------------	-------	--------------------------	-------	--------------------------

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 09/30/00 **Fiscal Year:** 09/30/00

* All facilities other than governmental must report on the accrual basis.

1		2		3		4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period			
1	15	Skilled (SNF)	15	5,475	1		
2		Skilled Pediatric (SNF/PED)			2		
3	36	Intermediate (ICF)	36	13,140	3		
4		Intermediate/DD			4		
5		Sheltered Care (SC)			5		
6		ICF/DD 16 or Less			6		
7	51	TOTALS	51	18,615	7		

1	2	3	4
---	---	---	---

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	1,319	104		1,423	8
9	SNF/PED					9
10	ICF	9,465	3,902		13,367	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,784	4,006		14,790	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) **79.45%**

79.45%

STATE OF ILLINOIS

Page 3

Facility Name & ID Number PERSHING CONVALESCENT HOME # 0001644 Report Period Beginning: 10/01/99 Ending: 9/30/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	106,219	10,530		116,749	11,823	128,572		128,572		1
2	Food Purchase		57,200		57,200		57,200	(1,122)	56,078		2
3	Housekeeping	27,983	15,950		43,933		43,933		43,933		3
4	Laundry	25,346	4,906		30,252		30,252		30,252		4
5	Heat and Other Utilities			27,000	27,000		27,000		27,000		5
6	Maintenance	9,776	24,257	2,515	36,548		36,548		36,548		6
7	Other (specify):* SCAVENGER			1,016	1,016		1,016		1,016		7
8	TOTAL General Services	169,324	112,843	30,531	312,698	11,823	324,521	(1,122)	323,399		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	534,167	22,391		556,558	(48,533)	508,025		508,025		10
10a	Therapy					34,485	34,485		34,485		10a
11	Activities	57,222	22		57,244	671	57,915		57,915		11
12	Social Services					41,282	41,282		41,282		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	591,389	22,413		613,802	27,905	641,707		641,707		16
	C. General Administration										
17	Administrative	35,302			35,302	(2,147)	33,155		33,155		17
18	Directors Fees										18
19	Professional Services			70,644	70,644	(38,630)	32,014	(3,916)	28,098		19
20	Dues, Fees, Subscriptions & Promotions			3,912	3,912	96	4,008		4,008		20
21	Clerical & General Office Expenses		9,986	24,723	34,709		34,709		34,709		21
22	Employee Benefits & Payroll Taxes			113,485	113,485		113,485		113,485		22
23	Inservice Training & Education										23
24	Travel and Seminar			696	696		696		696		24
25	Other Admin. Staff Transportation			426	426	2,147	2,573		2,573		25
26	Insurance-Prop.Liab.Malpractice			9,885	9,885		9,885		9,885		26
27	Other (specify):* CASUAL LAB-1834, MISC-1119			2,953	2,953	(1,834)	1,119		1,119		27
28	TOTAL General Administration	35,302	9,986	226,724	272,012	(40,368)	231,644	(3,916)	227,728		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	796,015	145,242	257,255	1,198,512	(640)	1,197,872	(5,038)	1,192,834		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			15,009	15,009		15,009	(7,084)	7,925			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,788	2,788		2,788	901	3,689			32
33	Real Estate Taxes			43,753	43,753		43,753		43,753			33
34	Rent-Facility & Grounds			60,000	60,000		60,000	(60,000)				34
35	Rent-Equipment & Vehicles			489	489		489		489			35
36	Other (specify):*											36
37	TOTAL Ownership			122,039	122,039		122,039	(66,183)	55,856			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					640	640	(640)				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			28,000	28,000		28,000		28,000			42
43	Other (specify):* EMP REC FAC-7508, PENALT-100			7,608	7,608		7,608	(7,608)				43
44	TOTAL Special Cost Centers			35,608	35,608	640	36,248	(8,248)	28,000			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	796,015	145,242	414,902	1,356,159		1,356,159	(79,469)	1,276,690			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(1,017)	30		9
10	Interest and Other Investment Income	901	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,122)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(7,508)	43		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(3,916)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(6,807)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (19,469)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(60,000)	34	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (60,000)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (79,469)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES			Sch. V Line	
	Amount	Reference		
1	PENALTIES	\$ (100)	43	1
2	AUTO DEPRECIATION FOR NON-CARE USE	(4,725)	30	2
3	DEPRECIATION NOT ALLOWED ON REPORT			3
4	FROM 1993-IRS ADJ	(1,342)	30	4
5	DENTIST FEE PAID BY PUBLIC AID	(640)	19	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49				49
50				50
51				51
52				52
53				53
54				54
55				55
56				56
57				57
58				58
59				59
60				60
61				61
62				62
63				63
64				64
65				65
66				66
67				67
68				68
69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	Total	(6,807)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PERSHING CONVALESCENT HOME# 0001644

Report Period Beginning:

10/01/99

Ending:

9/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,122)	0	0	0	0	0	0	0	0	0	0	(1,122)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,122)	0	0	0	0	0	0	0	0	0	0	(1,122)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(4,556)	0	0	0	0	0	0	0	0	0	0	(4,556)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(4,556)	0	0	0	0	0	0	0	0	0	0	(4,556)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(5,678)	0	0	0	0	0	0	0	0	0	0	(5,678)	29

Summary B

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

Facility Name & ID Number **PERSHING CONVALESCENT HOME**# **0001644**Report Period Beginning: **10/01/99**Ending: **9/30/00**

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
LUCILLE ENGELSMAN	100					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	33 REAL ESTATE TAX	\$ 43,753	LUCILLE ENGELSMAN	100.00%	\$ 43,753	\$	1
2	V	34 RENT		LUCILLE ENGELSMAN	100.00%	60,000	60,000	2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 43,753			\$ 103,753	\$ *	60,000 14

* Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS

Page 7

Facility Name & ID Number **PERSHING CONVALESCENT HOME** # **0001644** Report Period Beginning: 10/01/99 Ending: 9/30/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	LUCILLE ENGELSMAN	PRESIDENT	ADMINISTRATO	100.00		PART-TIME	P/T		\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number PERSHING CONVALESCENT HOME # 0001644 Report Period Beginning: 10/01/99 Ending: 9/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number (____) _____
 Fax Number (____) _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	N/A				\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number **PERSHING CONVALESCENT HOME** # **0001644** Report Period Beginning: **10/01/99** Ending: **9/30/00**

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related																		
	Long-Term																		
1	AMERICAN CHARTERED BANK	X		OPERATIONS	\$1,315.00	08/26/99	\$ 150,000	\$ 145,656	09-01-04	8.5000	\$ 14,804	1							
2												2							
3												3							
4												4							
5												5							
	Working Capital																		
6	AMERICAN CHARTERED BANK	X		CREDIT LINE		08/26/99	50,000	49,613	ON DEMAND	VARIABLE	4,400	6							
7												7							
8												8							
9	TOTAL Facility Related				\$1,315.00		\$ 200,000	\$ 195,269			\$ 19,204	9							
	B. Non-Facility Related*																		
10	HOMESIDE LENDING INC.		X	MORTGAGE-EMP REC FAC	\$686.00	07/01/84	63,000	15,940	04/2003	VARIABLE	1,205	10							
11	GLENVIEW STATE BANK		X	AUTO	\$468.00	07/03/96	19,251		07/03/00	7.7500	90	11							
12	GREAT LAKES CREDIT UNION		X	AUTO	\$535.00	06/05/98	21,725	10,486	05/05/02	8.5000	1,156	12							
13												13							
14	TOTAL Non-Facility Related				\$1,689.00		\$ 103,976	\$ 26,426			\$ 2,451	14							
15	TOTALS (line 9+line14)						\$ 303,976	\$ 221,695			\$ 21,655	15							

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **PERSHING CONVALESCENT HOME**# **0001644**Report Period Beginning: **10/01/99**Ending: **9/30/00****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	53,057	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	42,612	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(10,445)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	54,198	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For 19 _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	43,753	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995	58,079	8
	1996	39,576	9
	1997	40,826	10
	1998	42,935	11
	1999	43,753	12

9/12 OF 1999 TAX	32076		
10/3/00 PAYMENT	22122		
TOTAL	54198		

	FOR OFF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 1999 \$	13
14	PLUS APPEAL COST FROM LINE 5 \$	14
15	LESS REFUND FROM LINE 6 \$	15
16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

A.

Square Feet:

7,240

B.

General Construction Type:

Exterior

BR

Frame

Number of Stories

2

C.

Does the Operating Entity?

☐ (a) Own the Facility
 ☒ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D.

Does the Operating Entity?

☒ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E.

List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F.

Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:

N/A

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1		2,240	1961	\$	1
2		5,000	1964		2
3	TOTALS	7,240		\$ 7,283	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1964	1964	\$ 199,363	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		LEASEHOLD IMPROVEMENTS		1972	43,998					43,998	9
10				1979	2,600					2,600	10
11				1980	10,349					10,349	11
12				1981	2,107					2,107	12
13				1983	6,950					6,950	13
14				1983	187					187	14
15				1985	34,659					34,659	15
16				1986	10,150					10,150	16
17		WINDOWS		1989	29,450	935	31.5	935		10,245	17
18		ROOF		1993	11,700	371	31.5	371		2,878	18
19		ROOF REPAIR AND REMODELLING		1994	17,444	447	39	447		2,907	19
20		PARKING LOT PAVING, ASPHALT AND SEAL COATING		1995	12,199	857	15	813	(44)	6,632	20
21		GUTTER REPLACEMENT		1995	6,300	162	39	162		828	21
22		FIRE DOOR		1996	946	24	39	24		112	22
23		FLOORS		1996	1,000	26	39	26		119	23
24		BUILDING MATERIALS		1996	1,500	38	39	38		168	24
25		CONTRACTOR TO IMPROVE BUILDING		1996	3,000	77	39	77		337	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36		TOTAL (lines 4 thru 35)			\$ 393,902	\$ 2,937		\$ 2,893	\$ (44)	\$ 135,226	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **PERSHING CONVALESCENT HOME** # **0001644** Report Period Beginning: **10/01/99** Ending: **9/30/00**

XI. OWNERSHIP COSTS (continued)**C. Equipment Depreciation-Excluding Transportation. (See instructions.)**

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 27,659	\$ 2,063	\$ 3,523	\$ 1,460	7	\$ 26,123	37
38	Current Year Purchases	11,075	3,881	791	(3,090)	7	3,881	38
39	Fully Depreciated Assets	238,524					238,524	39
40								40
41	TOTALS	\$ 277,258	\$ 5,944	\$ 4,314	\$ (1,630)		\$ 268,528	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	PATIENT	89 BUICK SKYHAWK	1995	\$ 3,591	\$ 61	\$ 718	\$ 657	5	\$ 3,400	42
43										43
44										44
45										45
46	TOTALS			\$ 3,591	\$ 61	\$ 718	\$ 657		\$ 3,400	46

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 682,034 47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 8,942 48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 7,925 49
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ (1,017) 50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 407,154 51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	AUTO 83/84	\$ 11,908	\$	\$ 11,908	52
53	EMPLOYEE REC FACILITY	93,214	3,728	89,485	53
54	AUTO 1982	11,643		11,643	54
55	1995 LINCOLN	29,452	1,775	14,460	55
56	1996 LINCOLN	27,725	2,950	11,110	56
57	TOTALS	\$ 173,942	\$ 8,453	\$ 138,606	57

G. Construction-in-Progress

	Description	Cost	
58			58
59			59
60			60
61		\$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: **LUCILLE ENGELSMAN-RELATED PARTY**

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☒ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ Description:

(Attach a schedule detailing the breakdown of movable equipment)

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2001 \$

13. /2002 \$

14. /2003 \$

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
--	---	--

THIS HOME ONLY HIRES EXPERIENCED AND FULLY CERTIFIED AIDES.

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$ 9,009	1
2	Cash-Patient Deposits			2
	Accounts & Short-Term Notes Receivable-			
3	Patients (less allowance)			3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses		1,177	7
8	Accounts Receivable (owners or related parties)		356,476	8
9	Other(specify): PREPAID TAX		19,259	9
	TOTAL Current Assets			
10	(sum of lines 1 thru 9)	\$	\$ 385,921	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost		246,869	15
16	Equipment, at Historical Cost		454,789	16
17	Accumulated Depreciation (book methods)		(555,098)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization -			
20	Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
	TOTAL Long-Term Assets			
24	(sum of lines 11 thru 23)	\$	\$ 146,560	24
	TOTAL ASSETS			
25	(sum of lines 10 and 24)	\$	\$ 532,481	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$ 144,364	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable		6,224	30
	Accrued Taxes Payable			
31	(excluding real estate taxes)		616	31
32	Accrued Real Estate Taxes(Sch.IX-B)		54,198	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	CREDIT LINE		49,613	36
37	DUE EMPLOYEE		756	37
	TOTAL Current Liabilities			
38	(sum of lines 26 thru 37)	\$	\$ 255,771	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		156,141	39
40	Mortgage Payable		15,940	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
	TOTAL Long-Term Liabilities			
45	(sum of lines 39 thru 44)	\$	\$ 172,081	45
	TOTAL LIABILITIES			
46	(sum of lines 38 and 45)	\$	\$ 427,852	46
47	TOTAL EQUITY(page 18, line 24)	\$	\$ 104,629	47
	TOTAL LIABILITIES AND EQUITY			
48	(sum of lines 46 and 47)	\$	\$ 532,481	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 114,240	1
2	Restatements (describe):		2
3	CORRECTION TO PRIOR YEAR'S ADJUSTMENT	(2,290)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 111,950	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(8,376)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) deferred maintenance costs per sch xix-h not	1,055	15
16	Other (describe) on income statement		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (7,321)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 104,629	24 *

* This must agree with page 17, line 47.

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 1,348,228	1
2	Discounts and Allowances for all Levels	(394)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,347,834	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,347,834	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	312,698	31
32	Health Care	613,802	32
33	General Administration	272,012	33
	B. Capital Expense		
34	Ownership	122,039	34
	C. Ancillary Expense		
35	Special Cost Centers	7,608	35
36	Provider Participation Fee	28,000	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,356,159	40
41	Income before Income Taxes (line 30 minus line 40)**	(8,325)	41
42	Income Taxes	(51)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (8,376)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **PERSHING CONVALESCENT HOME**# **0001644**Report Period Beginning: **10/01/99**Ending: **9/30/00****XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,991	2,103	\$ 42,002	\$ 19.97	1
2	Assistant Director of Nursing					2
3	Registered Nurses	17,527	18,316	311,355	17.00	3
4	Licensed Practical Nurses					4
5	Nurse Aides & Orderlies	17,763	18,408	158,337	8.60	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	2,343	2,446	22,473	9.19	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,056	2,168	18,986	8.76	9
10	Activity Assistants					10
11	Social Service Workers	2,651	2,765	38,236	13.83	11
12	Dietician	9,030	9,190	106,219	11.56	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,376	1,384	9,776	7.06	17
18	Housekeepers	4,793	5,005	27,983	5.59	18
19	Laundry	4,404	4,434	25,346	5.72	19
20	Administrator	4,126	4,126	35,302	8.56	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	68,060	70,345	\$ 796,015 *	\$ 11.32	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	281	\$ 11,822	1-5	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	148	6,209	10A-5	40
41	Occupational Therapy Consultant	133	5,592	10A-5	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	37	1,044	12-3	45
46	Other(specify)				46
47	RECREATIONAL THERAPY	24	671	11-5	47
48					48
49	TOTAL (lines 35 - 48)	623	\$ 25,338		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	660	9,576	10-5	52
53	TOTAL (lines 50 - 52)	660	\$ 9,576		53

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

[illegible]

Facility Name & ID Number **PERSHING CONVALESCENT HOME**

STATE OF ILLINOIS

0001644

Report Period Beginning:

10/01/99

Ending:

Page 23

9/30/00

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? no
- (2) Are there any dues to nursing home associations included on the cost report? no
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political organization? no If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? 7 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 753 Line v10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation. _____
- (8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over _____
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 28,000
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation. _____

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? n/a
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ 0 Has any meal income been offset against related costs? no Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? no
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? n/a
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? yes
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? no
Firm Name: n/a The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? n/a
Attach invoices and a summary of services for all architect and appraisal fees.

PERSHING CONVALESCENT HOME

1644

10/01/99-09/30/00

RECLASSIFICATIONS:

1-RECLASSIFY EMPLOYEE USE OF AUTO BENEFIT IN SALARY EXPENSE TO STAFF
TRANSPORTATION.

2-RECLASSIFY NURSING SALARIES TO THERAPY.

3-RECLASSIFY PROFESSIONAL FEES TO PROPER LEVEL OF CARE AND TO
BACKGROUND CHECKS.

4-ALLOCATE SOCIAL SERVICES FROM NURSING SALARIES.

5-RECLASSIFY CASUAL LABOR TO NURSES AIDES.

ADJUSTMENTS:

A-TO ADJUST DEPRECIATION TO STRAIGHT LINE.

B-TO ADJUST FOR INTEREST ON AUTO-NOT USED FOR PATIENT RELATED ACTIVITIES
(INCLUDES REPAYMENT OF INTEREST AND USE BY EMPLOYEE)

C-TO ADJUST FOR EMPLOYEE RECREATIONAL FACILITY.

D-TO ADJUST FOR PENALTIES.

E-TO ADJUST FOR SALES TAX.

F-TO ADJUST FOR DEPRECIATION ON AUTO NOT USED FOR PATIENT ACTIVITIES.

G-TO ADJUST FOR DEPRECIATION NOT ALLOWED ON PUBLIC AID REPORT/

H-TO ADJUST FOR RENT TO RELATED PARTIES.

I- TO ADJUST FOR LEGAL FEES TO COMBAT REAL ESTATE TAXES.

J-TO ADJUST FOR DENTIST FEE PAID BY PUBLIC AID.

VI. COST CENTER ADJUSTMENTS

LINE 29

DENTIST FEE PAID BY PUBLIC AID	640
PENALTIES`	100
DEPRECIATION FOR NON PATIENT ACTIV	4725
DEPRECIATION ADDED FROM 1993 AUDIT	1342
TOTAL ADJUSTMENTS	<u>6807</u>

XVII INCOME STATEMENT

LINE 41

LOSS BEFORE TAX	-8325
EMPLOYEE REC FAC NOT ON 1120	7508
PENALTIES	100
DEFERRED MTN COSTS	<u>1055</u>
TAXABLE INCOME PER 1120	<u>338</u>

BILLS FOR LEGAL FEES ARE NOT ATTACHED AS THEY WERE ADJUSTED OUT.